

Nonpayroll

**Aflac's Application for Individual Life Insurance (ICC18B60000 Series)**

Application to: American Family Life Assurance Company of Columbus  
(herein referred to as Aflac)  
Worldwide Headquarters • Columbus, Georgia 31999

Policy Number

☐ New

**Please Print in Black Ink – To Be Completed by Proposed Insured**

Proposed Insured's Name \_\_\_\_\_  
Last First MI Suffix

DOB \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Current Weight \_\_\_\_\_ lbs. SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month/Day/Year (Required)

Driver's License Number \_\_\_\_\_ State of Issue \_\_\_\_\_ State of Birth \_\_\_\_\_

Proposed Insured's Address \_\_\_\_\_  
Street or Post Office Box Apt. No.

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Primary Telephone ( ) \_\_\_\_\_ Best Time to Call \_\_\_\_\_  
☐ Home ☐ Work ☐ Cell

Secondary Telephone ( ) \_\_\_\_\_ Best Time to Call \_\_\_\_\_  
☐ Home ☐ Work ☐ Cell

E-mail Address \_\_\_\_\_

I acknowledge I have access to the internet and I prefer to receive an electronic copy of my policy instead of a paper copy.

☐ Yes ☐ No

Does the Proposed Insured have any other life coverage with Aflac, not to include Voluntary Group Term Life?

☐ Yes ☐ No

If yes, give current policy number: \_\_\_\_\_

Will the purchase of this life insurance policy give the Proposed Insured more than \$250,000 total face value of life insurance coverage with Aflac?

☐ Yes ☐ No

If yes, a policy will not be issued; therefore, do not submit this application.

Will insuring any Dependent Child under this life insurance policy cause the total face value of all Aflac life insurance policies insuring such Dependent Child to exceed \$30,000?

☐ N/A ☐ Yes ☐ No

If yes, please list the name(s) of the Dependent Child(ren)

\_\_\_\_\_

The Dependent Child(ren) named is not eligible to be covered under the policy or any rider(s).

Are there other Dependent Children to be covered?

☐ Yes ☐ No

If no other Dependent Child(ren) to be covered, a rider will not be issued.

Does the Proposed Insured have any other life coverage or annuity contract with any other company?

☐ Yes ☐ No

If yes, please provide the current policy number and/or annuity contract and the name of the issuing insurance company: \_\_\_\_\_

Is the purchase of this policy intended to replace or change any life insurance or annuity now in force?

☐ Yes ☐ No

If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Is everyone to be covered a citizen of the United States?

☐ Yes ☐ No

If no, copies of such person's permanent visa or proof of permanent residence must be submitted with this application.

Is the Proposed Insured currently employed, a business owner/self-employed, or military?

☐ Yes ☐ No

If yes:

Name of Employer/Business: \_\_\_\_\_

Occupation/Job Title (Required): \_\_\_\_\_

Annual Income (Required): \_\_\_\_\_

Provide Tax ID number if self-employed: \_\_\_\_\_

If no, provide details below (i.e. retired, homemaker, disabled, other): \_\_\_\_\_

Within the last 12 months, has the Proposed Insured used tobacco/cannabinoid products, products containing nicotine, and/or any nicotine delivery system? ☐ Yes ☐ No

| CHECK COVERAGE DESIRED:                                                                                         | Issue Ages | Face Amount of Insurance |
|-----------------------------------------------------------------------------------------------------------------|------------|--------------------------|
| <b>WHOLE LIFE</b>                                                                                               |            |                          |
| <input type="checkbox"/> Whole Life Policy (Series ICC18B60100) <input type="checkbox"/> Automatic Premium Loan | 18-70      |                          |

|                                                                                                                                                                                        |       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|
| <b>Optional Rider available with Whole Life only (Proposed Insured Only)</b>                                                                                                           |       |  |
| <input type="checkbox"/> 10-Year Term Life Insurance Rider (Series ICC18B60050)<br><b>PLEASE NOTE: total number of units cannot be more than 50% of the Whole Life number of units</b> | 18-70 |  |

|                                                                   |       |  |
|-------------------------------------------------------------------|-------|--|
| <b>TERM LIFE</b>                                                  |       |  |
| <input type="checkbox"/> 10-Year Term Policy (Series ICC18B60200) | 18-70 |  |
| <input type="checkbox"/> 20-Year Term Policy (Series ICC18B60300) | 18-60 |  |
| <input type="checkbox"/> 30-Year Term Policy (Series ICC18B60400) | 18-50 |  |

|                                                                                               |
|-----------------------------------------------------------------------------------------------|
| <b>Optional Riders available with Whole or Term Life (Proposed Insured Only)</b>              |
| <input type="checkbox"/> Waiver of Premium Rider (Series ICC18B60051) Issue Ages 18-59        |
| <input type="checkbox"/> Accidental-Death Benefit Rider (Series ICC18B60052) Issue Ages 18-69 |

| Optional Child Rider                                                          | Issue Ages                 | Face Amount of Insurance |
|-------------------------------------------------------------------------------|----------------------------|--------------------------|
| <input type="checkbox"/> Child Term Life Insurance Rider (Series ICC18B60053) | 14 days*<br>to<br>17 years |                          |

\*The Effective Date of coverage for any eligible newborn Dependent Child will not begin until the later of: (1) the date any eligible newborn Dependent Child attains the age of 14 days or (2) the date any eligible newborn Dependent Child is first released from the hospital after birth.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| Billing Method                                 | Mode                                   |
|------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Direct                | <input type="checkbox"/> 01 Monthly    |
| <input type="checkbox"/> Bank Draft (B/D, ACH) | <input type="checkbox"/> 03 Quarterly  |
| <input type="checkbox"/> Credit Card (C/C)     | <input type="checkbox"/> 06 Semiannual |
|                                                | <input type="checkbox"/> 12 Annual     |

For Bank Draft / ACH or Credit Card billing method, an Authorization Form must accompany this application.

Billable Premium \$ \_\_\_\_\_ Premium Collected\* \$ \_\_\_\_\_

Assoc./Agent's No. \_\_\_\_\_ Sit. Code \_\_\_\_\_

**\*If a check or money order is collected, please leave a temporary life insurance agreement form with the applicant and submit a copy to Aflac Worldwide Headquarters.**

**PLEASE COMPLETE QUESTIONS 1-11. IF YOU ARE APPLYING FOR A CHILD TERM RIDER, THE QUESTIONS MUST BE COMPLETED FOR THE CHILD(REN).**

**Where used in any of the following questions, the terms 'treated' and 'treatment' include taking any medication.**

1. Has anyone to be covered ever been convicted of a crime or is anyone to be covered currently charged with a crime, including misdemeanor offenses and/or minor infractions, or currently incarcerated in any detention facility or penal institution, on parole, or probation? ☐ Yes ☐ No

2. (a) Within the last 12 months, has anyone to be covered been convicted of operating a vehicle

- while under the influence of alcohol or drugs, or had a driver's license revoked or suspended? ☐ Yes ☐ No
- (b) Within the last five years, has anyone to be covered been convicted two or more times with operating a vehicle while under the influence of alcohol or drugs or been convicted five or more times with a moving violation? ☐ Yes ☐ No

3. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following conditions? ☐ Yes ☐ No

|                                                                                          |                                              |
|------------------------------------------------------------------------------------------|----------------------------------------------|
| Acquired Immune Deficiency Syndrome (AIDS)                                               | Diabetes (Type II) diagnosed prior to age 30 |
| AIDS-related complex (ARC)                                                               | Diabetes and used tobacco after diagnosis    |
| Alzheimer's disease                                                                      | Emphysema                                    |
| Amyotrophic Lateral Sclerosis (ALS)                                                      | End stage renal failure                      |
| Bipolar disorder                                                                         | Heart attack prior to age 40                 |
| Cardiomyopathy                                                                           | Heart valve replacement or correction        |
| Chronic obstructive lung disease, including chronic obstructive pulmonary disease (COPD) | HIV-positive diagnosis                       |
| Chronic or relapsing pancreatitis                                                        | Implant of defibrillator                     |
| Chronic renal failure                                                                    | Major depression                             |
| Cirrhosis of liver                                                                       | Muscular dystrophy                           |
| Congestive heart failure                                                                 | Parkinson's disease                          |
| Coronary Artery Disease – more than two vessels                                          | Pulmonary Hypertension                       |
| Coronary Artery Disease and used tobacco after diagnosis                                 | Renal hypertension                           |
| Cystic fibrosis                                                                          | Schizophrenia                                |
| Dementia                                                                                 | Scleroderma                                  |
|                                                                                          | Systemic lupus                               |
|                                                                                          | Terminal condition                           |

4. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for any of the following conditions? ☐ Yes ☐ No

|                                                                                                   |                                                                                         |
|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Alcohol or drug abuse                                                                             | Leukemia                                                                                |
| Atrial fibrillation                                                                               | Liver disease or disorder (excluding Hepatitis A)                                       |
| Diabetes treated with insulin or injectable medication                                            | Lymphoma                                                                                |
| Diabetes with complications to include nephropathy, neuropathy or retinopathy                     | Malignant melanoma (Clark's Level III or higher, or a Breslow level greater than 1.5mm) |
| Heart attack                                                                                      | Multiple Sclerosis                                                                      |
| Heart surgery                                                                                     | Pulmonary Fibrosis                                                                      |
| Implant of pacemaker                                                                              | Stroke/TIA                                                                              |
| Internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder) | Suicide attempt                                                                         |
| Kidney disease or disorder (not including stones)                                                 |                                                                                         |

5. Within the last 12 months, has anyone to be covered been confined in a hospital or treatment facility for any mental or nervous disorder? ☐ Yes ☐ No

6. Has anyone to be covered ever had an organ transplant, or within the last five years discussed with a member of the medical profession the need to have an organ transplant? ☐ Yes ☐ No

**If you answered yes to any of Questions 1–6 was it the:**

☐ Proposed Insured ☐ Dependent Child?

**If Dependent Child, please list the name(s) of the Dependent Child(ren):**

**Any person(s) indicated above will not be covered under the policy or any riders. If the person indicated above is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

**If a Dependent Child, are there other Dependent Children to be covered? ☐ Yes ☐ No**

7. Has anyone to be covered ever been diagnosed by a member of the medical profession or within

the last five years been treated for any of the following conditions?

☐ Yes ☐ No

Anemia  
Any cyst, tumor or cancer  
Blood clotting defects/disorders  
Crohn's disease  
Depression  
Diabetes  
Heart disease or disorder (including congenital)

High blood pressure  
(hypertension)  
Kidney Disorder  
Lupus  
Neurological disorder or disease  
Respiratory disorder or disease  
Ulcerative Colitis

8. In the last two years, has anyone to be covered been hospitalized two or more times (excluding childbirth), or had surgery recommended by a member of the medical profession that has not yet been performed?

☐ Yes ☐ No

9. If Question 7 and/or 8 is answered yes, provide details below:

|            | Name of Individual(s) | Medical Condition(s) | Onset (mo/yr) | Surgery Performed or Recommended? (If yes, provide the type of procedure and date.) | For Hypertension and Diabetes, List the Average Reading (for the last three months). |
|------------|-----------------------|----------------------|---------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| Question 7 |                       |                      |               |                                                                                     |                                                                                      |
|            |                       |                      |               |                                                                                     |                                                                                      |
| Question 8 |                       |                      |               |                                                                                     |                                                                                      |
|            |                       |                      |               |                                                                                     |                                                                                      |

10. Within the last six weeks, has anyone to be covered been prescribed or taken any medication or cannabinoid recommended by a Physician (not including prescription contraceptives)?

☐ Yes ☐ No

If yes, please provide complete information below:

| Name of Individual(s) | Name of Medication | Frequency of Intake | Date First Prescribed | Medical Condition Taken For |
|-----------------------|--------------------|---------------------|-----------------------|-----------------------------|
|                       |                    |                     |                       |                             |
|                       |                    |                     |                       |                             |
|                       |                    |                     |                       |                             |
|                       |                    |                     |                       |                             |
|                       |                    |                     |                       |                             |
|                       |                    |                     |                       |                             |
|                       |                    |                     |                       |                             |

Your Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
(if no regular Physician, Physician last seen)

Address \_\_\_\_\_

Date Last Seen by Physician \_\_\_\_\_ Reason for Last Visit \_\_\_\_\_

11. Has anyone to be covered ever engaged in or within the next two years do you intend to engage in any of the following hazardous sports or avocations: sky diving, scuba diving, hang gliding,

motorized vehicle racing, cave exploration, bungee jumping, parachuting, mountain or rock climbing, or aviation (except any aviation on a commercial airline flight or first responder flight)?

☐ Yes ☐ No

If yes, list the activity and frequency \_\_\_\_\_

**Additional Underwriting May Be Required.**

**BENEFICIARY INFORMATION**

**PLEASE NOTE:** If no beneficiary is named, your beneficiary will be your surviving spouse, if any, otherwise it will be your estate.

If you name a trust as your beneficiary, please include full name of trust.

We do not recommend that you name a minor child as your beneficiary. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid until Aflac receives legal documentation identifying the person with authority to receive the benefits on behalf of such beneficiary or such beneficiary reaches the age of majority as defined by applicable state law. We suggest you obtain legal advice before naming a minor child as your beneficiary.

If you reside in a community property state, are married, and designate a person other than your spouse as the primary beneficiary, your spouse may have rights to the death benefit of this policy under state law even if you choose not to name them as your beneficiary. We recommend submitting documentation signed by your spouse consenting to your beneficiary designation and waiving any right to proceeds payable under the policy. If you are unsure whether these laws apply to you, consult with your legal or tax advisor to determine whether submission of such documentation is necessary. Unless Aflac has been notified of a community or marital property interest in this policy, Aflac will presume that no such interest exists and disclaims any responsibility for determining the applicability of community property laws or the validity of the beneficiary designation. However, if your spouse claims a community property interest in the proceeds, it may delay the payment of proceeds under the policy. By signing this application, you agree to indemnify and hold Aflac harmless from the consequences of making the designation requested in this application.

**Primary Beneficiary(ies):**  
100%

**NOTE:** Total % of Proceeds must equal

(1) Name \_\_\_\_\_ % of Proceeds \_\_\_\_\_  
Last Name First Name MI

Or Trustee(s) of \_\_\_\_\_  
Name of Trust

Trust under trust agreement dated \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Telephone No. \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

(2) Name \_\_\_\_\_ % of Proceeds \_\_\_\_\_  
Last Name First Name MI

Or Trustee(s) of \_\_\_\_\_  
Name of Trust

Trust under trust agreement dated \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Telephone No. \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

**Contingent Beneficiary(ies):**  
**100%**

**NOTE: Total % of Proceeds must equal**

(1) Name \_\_\_\_\_ % of Proceeds \_\_\_\_\_  
Last Name First Name MI

Or Trustee(s) of \_\_\_\_\_  
Name of Trust

Trust under trust agreement dated \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Telephone No. \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

(2) Name \_\_\_\_\_ % of Proceeds \_\_\_\_\_  
Last Name First Name MI

Or Trustee(s) of \_\_\_\_\_  
Name of Trust

Trust under trust agreement dated \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Telephone No. \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

**STATEMENTS AND AGREEMENTS**

- I agree the Effective Date of the policy may not be the date I requested or the date I signed this application. I understand the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
- I acknowledge that I have been informed whether there is/are any optional rider(s) available. If any optional rider(s) is/are available, then I acknowledge that I have personally determined which, if any, is/are best for me.

**Proposed Insured's Initials** \_\_\_\_\_

- I acknowledge receipt of, if applicable:  
☐ Replacement Notice ☐ Life Buyer's Guide
- I understand (1) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers (if any), constitutes the entire contract of insurance, and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I have read, or had read to me, the statements and answers I have provided on this application. I understand this policy and/or rider(s) is/are to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand all statements made in this application are deemed representations and not warranties, but material misrepresentations herein may result in loss of coverage under this policy. I will notify Aflac of any changes in the statements or answers given in this application between the time of application and delivery of the policy.
- I understand Aflac will have no liability until (1) a policy is issued on this application and delivered, and (2) the first premium due is paid in full while each Proposed Insured is alive.
- I have reviewed the benefits and premium of the insurance policy and/or rider(s) that I am applying for and agree to the following:
  - I understand the impact that the premium for this coverage has on my paycheck/income;
  - I understand the impact that the total Aflac premium for this coverage and any other Aflac coverage has on my paycheck/income and believe it to be appropriate for me; and

- I have considered all of my existing insurance coverage, with Aflac and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. This determination was made by examining the totality of my circumstances, including, but not limited to, my income and assets, current need for insurance and existing insurance program, if any, when compared to the values, benefits and costs of the recommended policy. I further understand that I can contact Aflac and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

**Proposed Insured's Initials** \_\_\_\_\_

#### **NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim, or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a Written Request to Aflac Worldwide Headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

#### **AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, pharmacy benefit manager, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, prescription drug history, or any other medical or nonmedical facts that are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I also authorize Aflac to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau). I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Policy Service, 1932 Wynnton Road, Columbus, Georgia 31999.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this application is signed. These time limits comply with the time limit, if any, permitted by applicable law in the jurisdiction where the policy is delivered or issued for delivery.

I agree that a copy of this authorization is as valid as the original.

### INFORMATION REGARDING THE MIB PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Aflac, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

Signed and Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Date

Proposed Insured's Signature (X) \_\_\_\_\_

Owner's Name \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_  
(if other than Proposed Insured)

Address \_\_\_\_\_  
Street or Post Office Box Apt. No.

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Owner's Signature, if Other Than Proposed Insured \_\_\_\_\_ on \_\_\_\_\_  
Date

**WAS THE ASSOCIATE/AGENT PRESENT AT THE TIME THE APPLICATION WAS COMPLETED?** ☐ Yes ☐ No

If yes, I certify each question was asked of the Proposed Insured and answered as recorded. All answers above are correct to the best of my knowledge. I further certify that I have explained to the Owner all exceptions and limitations pertaining to the coverage(s) applied for. I hereby certify that I know nothing affecting the insurability of the Applicant, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Aflac's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

To the best of my knowledge, this policy will ☐ will not ☐ replace or change any existing life insurance or annuity policy(ies).

Associate's/Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Licensed Associate/Agent

Witness' Name, if no Associate/Agent present \_\_\_\_\_

Witness' Signature \_\_\_\_\_ Date \_\_\_\_\_

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.  
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).  
VISIT OUR WEB SITE AT AFLAC.COM.**